



Notice of Independent Review Decision

Date notice sent to all parties: July 18, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chronic pain management program X 80 hours (97799)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ **Upheld** (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
847.2	97799	CP	Prosp.	80					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Certification of independence of the reviewer and TDI case assignment.
2. TDI case assignment.
3. Letters of denial 06/05/12 & 06/19/12, including the screening criteria used in the denial.
4. Designated doctor exam 06/29/12
5. Request for reconsideration 06/12/12.
6. Behavioral evaluation and updated request for services 04/16/12.
7. Individual progress notes (6 visits) 04/20/11 – 05/17/11.
8. Lab results 12/14/11, 02/08, 04/16 & 06/05/12.
9. Electrodiagnostic consultation report 03/23/11 and manual muscle strength exam (shoulder) 03/15/12.
10. Progress notes, MD (specialty unknown) 01/24/11 – 05/18/12.
11. Neurospine specialist evaluations 02/25/11 & 04/14/11.
12. MRI 02/11/11.
13. Physical performance evaluation 04/04/11 and impairment evaluation 06/08/11.
14. Functional capacity evaluations 02/21, 05/27, 07/27/11 and 05/25/12.

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15. Assessments and treatment notes 01/12/12 – 05/29/12. (Notes for the period 01/18/11 thru 12/21/11 available upon request.)

PATIENT CLINICAL HISTORY [SUMMARY]:

This individual sustained a back injury while pushing a cart at work in xx/xx. Her job was that of a people greeter. Numerous modalities have been utilized including physical therapy, injections, medications, and work hardening. She underwent a right L5/S1 microdiscectomy in October 2010. Current medications include ibuprofen, gabapentin, and lidocaine. Psychological evaluation reveals somatic dysfunction, depression, and anxiety. The Functional Capacity Evaluation on 05/25/12 revealed her capabilities as that of sedentary/light activity. Her job requirement is that of light activity.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

ODG requirement number two states there should be an absence of other options prior to consideration of a behavioral pain management program. This individual displays depression and anxiety, the first line of treatment for which is antidepressants. There is no indication that antidepressants have been utilized. A behavioral pain management program is not medically necessary since less intense modalities, i.e. antidepressants, have not been utilized.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)